Inlet Pediatrics
PO Box 4920
Murrells Inlet, SC 29576
(843) 652-3300 fax (843) 652-3200

Authorization for Release of Medical Information

Patient Name:_____ DOB_____

Address:_____ Phone_____

_____

I hereby authorize medical information relating to my treatment to be sent:

To/From	To/From
Inlet Pediatrics PO Box 4920 Murrells Inlet, SC 29576	_____ _____ _____ Phone_____ Fax_____

Covering the time period of: from (date) _____ to (date)_____

Specific information to release:

All Records Immunization Records Consultation Records
X Ray Reports Laboratory Reports Billing/Insurance Info
Other:_____

For the purpose of:

Transfer Insurance Continuation of Care
Legal Personal Reasons
Other:_____

I understand that the practice/facility releasing this information is hereby released from all legal liability that may arise from the release of the information requested. I understand that this information is to be disclosed for the purpose stated above and that purpose only. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, and any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s). The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that this consent is subject to revocation by me at any time and, unless an earlier date is specified, that it automatically expires (60) days after the date below or automatically when the records requested on this authorization have been released. I understand that, unless otherwise provided by law, there may be a fee to cove the cost of copying and handling my records.

Signature:_____ Date:_____

Relationship:_____ Witness:_____